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Iraq War and Federal VA Cuts Create a Flurry of News Items ——Meager Federal program felt especially east of the Cascades

By Emmett Early

In a letter to a veterans' representative from the Spokane VA Hospital, the writer chided him for sending a veteran to the hospital to apply for health care. The letter from the Registration/Eligibility section stated that the veteran was given an ID card, but could well have written for the application for the ID card, because he will not need it "until he begins to be seen in primary care which he will probably not get for a year or two because we have such a long waiting list for primary care."

Another report in the form of a letter from an east-of-the-mountains contractor states that homeless veterans were not given services at the same VAMC because they had not served two years or more in the military. This is quite a departure from the old 180 days of service required in the past.

All this comes in conjunction with a flurry of newspaper articles that take the Veterans Affairs hospital system to task. In a spate of headlines recently in local newspapers, the Federal Department of Veterans Affairs nationwide group of 115 hospitals came under scrutiny from diverse sources. In the *Seattle PI*, [4/12/03, p. A14] the Associated Press quoted a study conducted for the VA by the Harvard Medical School and other research groups stating that the "heart attack victims who sought care at Veterans Affairs hospitals had higher death rates than Medicare patients treated at community facilities." The article, headlined "Heart attack victims fared less well at VA hospitals," stated that "one of the most glaring findings was that even when veterans were in facilities that had the technology and equipment to provide more invasive procedures such as angioplasty or catheterization, veterans were less likely to receive that kind of care."

The article quoted VA Secretary Anthony Principi as saying that "the findings...were unacceptable and immediate action is required and will be taken."

In the 4/14/03 *Seattle PI*, also on page 14, an article by Robert Pear of the *New York Times* stated that "the Bush administration has ordered a nationwide review of medical research at 115 veterans hospitals and has halted some studies after investigators found serious violations of federal rules, including some that may have contributed to the deaths of patients." The investigators did not cite northwest VA hospitals as being among those who had violated research protocols.

Budget Cuts Proposed

The *Seattle Weekly* ran a story by Rick Anderson [April 9-15, 2003, p. 17-20], "Crippled Home Front: The Department of Veterans Affairs is being targeted for billions in cuts." He wrote, "Last year, the VA, the second-largest government agency (behind the Defense Department) which operates the nation's largest hospital system, treated 1.4 million more veterans than in 1996, with 20,000 fewer employees." He noted that a House Budget Committee was proposing a 15 billion dollar cut over 10 years, with $463 million "slashed from next year's budget." The *Weekly* cited a DAV representative as testifying that the VA is already underfunded "by almost $2 billion."

The *Weekly* article took notice of the current war and the number of veterans it would generate, many with disabilities and traumas to contend with. Under the heading "Past Wars, Future Patients," Anderson cites the "mystery illnesses" arising from each war, not the least of which were the genetic consequences of Agent Orange and the various sequelae of the Gulf War Syndrome. The reporter also wondered about the combat veterans being created in the current U.S. war.

War's Effect On War Veterans

Reporter Lynn Thompson of the *Seattle Times* published an article on April 16, 2003 ["This is an agonizing time for Vietnam vets," p. 16], following her visit to a combat veterans' therapy group in Everett. She reported that several of the veterans in the group expressed worry that the federal VA,

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Journal of Traumatic Stress Devotes April Issue to Crime Victims—Judith Lewis Herman notes the stressors of legal proceedings on victims

By EE

The April issue of the *Journal of Traumatic Stress* [2003, 16(2)] featured articles exclusively devoted to the mental health care of crime victims. These articles were first presented to the Mental Health Needs of Crime Victims Symposium held in Washington DC in October, 1999. They were commissioned by the Office for Victims of Crime and the National Institute of Justice. Included are articles on epidemiology and outcomes, assessment, legal intervention for child victims, the secondary traumatic stress effects on those working with crime victims, therapeutic interventions with child and adult victims.

Harvard psychiatrist and author Judith Lewis Herman presented an important discussion of the the impact of legal interventions on crime victims ["The Mental Health of Crime Victims: Impact of Legal Interventions," pp. 159-166]. Dr. Herman's article focused on the problems created by an adversarial legal system that involves defending the rights of the accused while seeking justice. Dr. Herman writes:

"The mental health needs of crime victims are often diametrically opposed to the requirements of legal proceedings. Victims need social acknowledgment and support; the court requires them to endure a public challenge of their credibility. Victims need to establish a sense of power and control over their lives; the court requires them to submit to a complex set of rules and procedures that they may not understand, and over which they have no control. Victims need an opportunity to tell their stories in their own way, in a setting of their choice; the court requires them to respond to a set of yes-or-no questions that break down any personal attempt to construct a coherent and meaningful narrative. Victims often need to control or limit their exposure to specific reminders of the trauma; the court requires them to relive the experience by directly confronting the perpetrator. Mental health workers who serve victims commonly report the impression that their patients' traumatic symptoms are worsened by negative contracts with the justice system (...)" (pp 159-160).

C&P Compared to Legal Proceedings

It has been observed by followers of the federal VA Compensation and Pension Process (C&P), that it is a quasi-legal system that, while not adversarial, requires the veteran with a PTSD claim, to undergo an examination by a stranger in a setting that is not of his or her choosing, and over which he or she has no control. This comparison is especially valid for those who were traumatized in a military setting by criminal activity, as well as those who were traumatized by the abuses and mistakes of those in authority. [See also "PTSD and Control," page 12 of this edition.]

Veterans who were traumatized in situations in which the government is culpable have stated that they feel the federal government is the adversary. One veteran client recently likened going to the VA hospital with entering a jail. Even if the C&P examiner is professional and compassionate in his or her application of the examination procedure, the veteran may likely feel disturbed. For example, if a young woman was raped in the military, and if the crime was not vigorously investigated and prosecuted, she may feel that justice not only was not served, but would not be served in the future. The C&P examination then has the potential to become a surrogate trial of her credibility.

Dr. Herman makes a case that the role of victim advocates is often significant in criminal proceedings involving domestic crimes. The advocate explains the proceedings and guides the victim through the confusing and frightening process. I have spoken to a number of men who were wounded in combat or in combat related accidents in which they were granted compensation upon discharge, and then discovered their disability reduced or eliminated. They did not pursue their righteous claim because they were bewildered or daunted by the complicated process. The recent news that the federal VA was cutting back on its outreach to veterans is significant in that it eliminates this helpful role of guidance. State funding for service officers, who are in the role of veterans' advocates, has also been trimmed.

Crime victims, as Dr. Herman and others have observed, often feel guilty *because* they were victimized. The VA C&P process *adjudicates* the claim in a quasi-legal proceeding that examines the evidence and arrives at a decision that may be appealed, further adjudicated, and then appealed again. ##

"Service-Connected" Disability Granted to Patient Injured at Veterans Affairs Hospital

In a recent ruling the Federal Court of Appeals gave service-connected disability benefits to a veteran paralyzed during surgery at a VA hospital. The Court of Appeals for Veterans Claims ruled that the U.S. Code includes a provision for veterans disabled as a result of treatment at a Veterans Affairs hospital.

In a May 7, 2003, decision in the case of Dee W. Kilpatrick v. Veterans Affairs Department, the Court of Appeals for the Federal Circuit upheld the Veterans Court decision ruling that Title 38, Section 2101(a) of the United States Code entitled the veteran to the same benefits he would have received had he been injured during military service. ##

PTSD Program Site Visits - Part III

By TS

When the *RAQ* first started to offer these roadway missives last year, someone did not do the math. The *RAQ* is published four times each year and there are 27 separate sites to visit annually. Generally, I only report on two to four contractor visits per RAQ edition. This means that I will never catch up to the present time. This will confirm the suspicion that I am, at least for now, a living, breathing anachronism, ever struggling to catch-up. In fact, I will fall behind each year by about 15 reports. EE, *the Editor*, feels that perhaps we should resort to some sort of supplemental edition and tidy-up my leftover stories. Especially since I recently finished all of the actual site visits for this year. The idea of a contractor centerfold edition was an amusing one, but will not likely appear in the near future.

Bruce Harmon, M. Ed., LMHC
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When one thinks about the Westside of Washington State, there are many places of beauty and peace found up and down the entire leading edge of the state. So when the village name "Renton" is heard by most Washingtonians, few would think of restful, comfortable, or sanctuary as synonyms. More often one thinks of Microsoft, Boeing, traffic, congestion, the infamous "S" curves. Some immediately think of the professional counseling offices of Bruce Harmon. Resting on a bluff overlooking the Renton Valley, Eagle Ridge Professional Center has, as the name implies, a bird's eye view of the surrounding area. Here Bruce Harmon shares a delightful suite of offices. The visitor is met by a warm and comfortable setting, that is filled with colorful oil paintings from many exotic places from around the world. Most of these appear to be items that Bruce has acquired over the years. All tell stories of journeys taken by Bruce and his life partner and colleague. Each picture begs to be asked about, somewhat like an eager but well disciplined dog awaits an owner's permission to come play with a visitor. The pictures offer far more than what one would have considered possible, and the telling of the story behind the story leads one to realize that Bruce is a richly diverse person. Someone who can readily comprehend the deeper side of the lives he hears of daily.

Bruce is a combat Vietnam veteran. He was a junior officer, and was wounded. I first met Bruce in 1981 or 1982 when he delivered a federal Vet Center contract to my office at Skagit CMHC, Mount Vernon. He knew little about me, and tolerated well my inane comment about his having been an officer. But his hearing and mine are nearly equal in their lacking, so I might have actually escaped (until now) his even knowing that I made a slightly off the mark comment about his "officer" status.

Former Vet Center Team Leader

Over the years Bruce has woven himself in and out of government. He left the Seattle Vet Center with the rank of Team Leader (TL), which the more observant reader will note is "LT" (the abbreviation for lieutenant) backwards, to become the Assistant Director of Washington State Department of Veterans Affairs. Bruce was instrumental in the development of the WDVA PTSD Program. He remained at WDVA for a few years, long enough for him to conduct at least one, perhaps two, site visits at my Mount Vernon office when I was a WDVA PTSD Contractor. I think this was in 1985.

HIPPA Organized

It is one of those odd turns of fate that I am again at Bruce's office conducting what is my fifth site visit of *his* services under the King County Veteran Program/WDVA PTSD Program. And as site visits go, Bruce is always fully prepared. I select charts at random and pour over progress notes and compare them to billings at a fevered pitch. I actually select extra charts to see if I might get lucky and find just one error. None are discovered in these orderly and well organized charts. Not only that, Bruce begins to hand me page after page of HIPAA forms, all organized for clients to read and sign. Further, since the King County funded *faction* of the WDVA PTSD Program is involved in a long term outcome study, Bruce is fully prepared to show me just how he has this somewhat dreary test-and-retest task organized. He is one organized therapist! *Must have been an officer!*

Former Officer and President

Bruce has also had a very active professional life that bears mentioning. He is the past President of the Washington State Mental Health Counselors Association. His early work lead to the Certification of Mental Health Counselors, and eventually licensing of this specialty. Many mental health professionals in Washington State owe Bruce a professional "thank you" for his leadership in this effort.

The Gold Acorn Award

Also, Thank you, Bruce, for all the years of consistently high quality service to fellow veterans and their family members. Your great work has earned an "A" for this site visit. There are things that are not easily counted, scored, and tabulated, when determining success. One of the clearest marks of success is when you have earned the respect of both veteran clients and your colleagues. The other is that you have won the WDVA PTSD Program *Golden Acorn Award, with two Oak Leaf Clusters.* Nice work!

(Continued on page 6, see *Site Visits)*

Equine-Facilitated Psychotherapy

By Paul C. Daley, Ph.D.

There are various "styles" of Equine-Facilitated Psychotherapy (EFP). Mine is best thought of as a "trail ride" style. Most EFP occurs within an arena, but I can only ride in a circle so many times before it is not fun for me any more.

At its simplest, EFP is no more than psychotherapy in a different location. At its best, it is psychotherapy in a different location with novel learning opportunities, and the opportunity to use the healing power of animals and recreation. (I will not bother to summarize it here, but suffice it to say that there is a growing and substantial body of research that describes the mental health benefits of recreation, relationships with animals, and, more specifically, the benefits of using horses in psychotherapy.)

Mary & Fadjanette

Mary (not her real name) is a very bright, highly educated woman married to a very bright, highly educated man. She is unhappy in her marriage, but she does not think she should be, as it is very clear that her husband is one of the "good guys" amongst males. He is educated, kind, likes to talk, is open about his feelings, loves her, and wants to make her happy. He also does a bunch of irritating things that Mary thinks should not bother her.

Mary asked to do an EFP session. I had been seeing her for several months before that session. Her husband came with her, but he left as soon as we left, and he came back a couple hours later. My EFP sessions start with paperwork. Clients have already signed my Office Policy statement before they arrive at the trailhead (which includes a paragraph on EFP). At the trailhead, I go through a cute-but-serious quick lesson in horseback riding. I teach the client how to mount up, the "good end" versus the "bad end" of the horse, the "brakes," the "emergency exit" (and when not to use it), "steering," PFOs (Potential Freak-Outs), etc. My horse is a four year old magic horse (I took her on a trail ride the second time I rode her), and my "client horse" is a 20 year old, gentle, old mare who would have difficulty mustering a freak out if she was paid to! I recommend helmets, but I do not require them. My "horses are dangerous, and I am aware of it"/risk awareness form strongly encourages using helmets and highlights all the bad things that can happen when riding horses. So far, every client has elected to wear a helmet.

Mary was scared of the idea of an EFP session when she was just thinking about it. Live and in person, the horses scared her even more (because they are so big and powerful), and the risk awareness form scared her yet more. Part of how we grow as people is facing our fears. I would have let her out of the whole session if she wanted, but she decided to risk it. As part of my "lessons in riding"

Paul C. Daley, Ph.D. is a licensed psychologist and WDVA contractor in private practice in Port Angeles, WA. His love of horses started with a family vacation when he was 13 years old, lay dormant for 30 years, and blossomed again when his youngest son – then 10 years old – expressed an interest in horses. He owns four horses, three since they were very young, trained those three, and brags that the baby of the lot is practically magic, she was so easy to train.

mini-lecture, I demonstrate things on her horse (e.g., "braking and steering"), so she could see that Fadjannette is handily handle-able, at least by me. (Fadjannette happens to be a very smart, very well trained old horse, so she "demonstrates" very well.)

Once mounted up, I told Mary that Fadjannette is now not a horse; she is her "life," and her assignment is to make her life go the way she wants it to go. As we started down the trail, I focus on assessing her anxiety, and Mary was, like most people, quick to bring her anxiety down to a manageable, slightly elevated level quite easily. Our session focused on the same topics we might focus on in the office. It is easy for the rider in front to hear, but more difficult for the one in the back to hear. I talk loud, and turn in the saddle a great deal, and we communicated well enough.

Mary's first problem with her "life" was that Fadjannette has an eating disorder. She likes to eat. She bent her head down to munch on something, stopping dead in her tracks. Mary asked me what she wanted to do about that, and I told

(Continued on page 5, see *EFP.*)

***EFP*, Continued from page 4.**

her I did not have the slightest idea what she wanted to do about that, it was her "life." She initially decided that she wanted her "life" to eat, but it quickly became clear that her "life" would spend the entire session grazing if she let her. So she decided she did not want her life to stop and eat anymore, and she bent her head over toward Fadjanette's head and commanded – with girlish forcefulness – "No!" Her "life," as you might guess, continued to eat. Mary looked helplessly at me. I told her it was her "life," and she again decided that she wanted to let her "life" eat, clearly a self-deceptive decision, and clearly symbolic of the decisions she was making with her actual life/marriage. At some point, she decided that she wanted to move on, and she asked me how to get Fadjannette's head up. I told her "pull on it," which she did carefully and gently so that her "life" would not experience any discomforting emotions. Her "life" kept eating. "Pull hard!" It took her three tries, but she pulled Fadjannette's head up, and we continued on, talking about the normal "stuff" of her life (mostly her marriage).

As with many things in life, Mary's "life" never got over her eating disorder. Mary adapted to the problem quickly, and, by the end of the ride, her "life" was not stopping to graze anymore, except when Mary decided it was time.

There were also some wonderful peaceful moments along the ride, sitting in the sun, talking, looking out over the meadows and vistas. It is different sitting quietly in the saddle as the horses move around grazing than it is sitting in a chair or on a sofa.

Fadjannette Wants the Lead.

When we headed on, Mary had her next "life" problem. Fadjannette decided she wanted to be the young vital horse in the lead. I kept cutting her off, asking Mary if she wanted to be in the lead, and Mary kept saying she did not want to be in the lead, but acted like her "life" was the boss, not her. For some reason, she then decided she that she did want to be in the lead, and I let her go. Almost immediately, she wanted me back in the lead, and she talked about the insight she gained in that experience. She said that that was how she functioned in her marriage: she preferred letting her husband lead, and was very uncomfortable with taking the lead, but then she would criticize him, from her one-back position, if he led her "wrong." She was surprised at how unpleasant it felt to her to be in the lead, the one in front, the one in charge.

Most of the rest of the session was essentially as we might have in the office, but more fun. At one point, we had to decide whether to risk raising somebody's ire by deciding whether to back track or go into an area that looked like it was meant to be out of bounds. Mary is not a rule violator, and I think it felt good to her to break a little rule.

By the end of the session, Mary was comfortably in the lead and fully in control of her "life." And aglow with it. ##

WDVA contractor and Port Angeles psychologist Paul Daley is seen above reflecting on his work as an equine-facilitated psychotherapist.

Below Paul Daley is seen on an equine-facilitated journey with his wife Cathy.

(*Site Visits*, Continued from page 3.)

Thomas Wear, Ph.D.
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Dr. Tom Wear is certainly not new to mental health, private practice, or the treatment of trauma in wider populations. He is especially well versed in treating various other disorders thought to have their roots in complex traumatic experience, especially fibromyalgia. For the past six years he has been working with veterans within our program. Tom Wear shares a suite of offices with RAQ Editor, Emmett Early in the University District, on newly paved University Avenue.

Repeat readers of this site visit travelogue, will recall the reported presence of a mystery aroma that has very subtly hung in the air of these offices for as long as I can recall. I reported it during Emmett's site visit as "an other world aroma", and I am about to revel the source, and its capacity to influence therapeutically.

Olfactory Mystery

This minor olfactory mystery was solved one day about a year ago, when Tom and I were taking, and out of no where appeared a well used pipe. An old briar worthy of a site visit and an interview of its own, Tom lit this relic and drew one puff and put it down. An ambrosia like smoke poured into the room, lingering not unlike cathedral incense. This all happened without the slightest detectable level of compunction on Tom's part, or the tiniest acknowledgement that in today's world, smoking in public is a capital offense. (Isn't it?)

The aroma of that particular tobacco was associated for me with a time in my life when I was struggling with the definition of adulthood (has that ever stopped?), while in the military and attempting to attend the U of New Hampshire. The smoke from Tom's pipe gathered me up like something from a genie being released from a bottle, lifted me out of Tom Wear's office, and deposited on the coast of New Hampshire. There, sitting on a rock 36 years ago, reading for the first time torturing lines from T.S. Elliott's *Wasteland.* In fact, a whole set of memories associated with this aroma opened several portals to emotional memories long indexed and filed away. These recollections were not to leave me for several days to follow. Is this what *aroma therapy* is all about?

I had to ask Tom, if he smoked the pipe when patients were present. The question leaped from my mouth before thinking—so conditioned we are these days to the offensive aspects of smoking. He said, "No". I was relieved since I did not have to invoke some arcane prohibition from the UCMJ or report him to Homeland Security.

The experience created for me a moment to remember that I pondered for sometime afterward. I came to realized that Tom Wear, like many senior therapists, is a rich collection of life experiences. Sets of "in the world experiences" just waiting to be elicited in a timely fashion for the benefit of their clients. I also thought that therapy often has far less to do with hearing about a symptom and then prescribing a technique to repair, remediate, rectify, and reframe the complaint (in six sessions) to the satisfaction of managed health care non-clinicians. It is much more than technique could ever address.

While Dr. Wear has always impressed me as a person who has unique and honest responses to the thoughts and ideas of others, he is also very insightful, caring, and contemplative. Treatment in his office is a special blend of all the approved professional applications and considerations, plus those collective experiences of a life time spent in finding answers. Therapy, with Dr. Wear, seems to be the application of his unique personality, rich asides, an assortment of evolving ideas, sometimes seemingly remote associations, which all turn out to actually be central to the core problem or conundrum being considered therapeutically. Oh yes, there is also the willingness to explore important thoughts that might never be urged into the light of day in most psychotherapy practices.

Sensory Cues

Life's most egregious wounds, require unique therapeutic events and new experiences that will urge people on to encounter themselves anew. Sometimes this encouragement may come in the form of planned or serendipitously *provoked senses*. Our senses, like word-triggers, are a neurological index to our memories of traumatic and happier outcomes, fearful and peaceful places, comfortable and disquieting recollections. Therapy should be able to find and bring some of these dual connections to consciousness. I have had those associations when I do site visits to Tom Wear's office. I hear him discuss treatment methods and considerations that are thoughtful, respectful, and proactive of health. What he offers trauma survivors is unique, beneficial, and important to their healing process. Even clients with complex PTSD and complicated dissociative elements.

The audit of Tom's client charts and billings wins him the universally sought after "A", and our thanks for your special work with veterans and their families. We are honored to have you in the veteran trauma treatment community. ##

Emmett Early Authors Second Book

Regular readers of the *RAQ* will know that Editor Early has , for several years, been the sole contributor to our Movie Review section. In recent weeks, with a level of fanfare becoming someone of Dr. Early's towering humility, his second book was released. *The war veteran in films,* published by McFarland & Company, deftly examines 125 well known and obscure films. The book is organized according to themes that allow the thoughtful reader to comprehend the messages within the medium. Expect a review of this new work in the next edition of the *RAQ*. Emmett authored *The Raven's Return - The influence of psychological trauma on individuals and culture* (Chiron Publications) in 1993. Congratulations Emmett, on your latest unique and engaging contribution to the literature on war veterans and culture. # *ts*

Autoimmune Diseases Linked to PTSD

—Comorbid disorders especially involved

In a paper presented to the annual meeting of the American Psychosomatic Society, Joseph Boscarino, Ph.D., MPH, Vietnam War veteran and senior scientist at the New York Academy of Medicine, reported his research that compared Vietnam War veterans with theater veterans in a large sample. Dr Boscarino compared 1,972 era veterans with 2,490 "theater" veterans. He compared the medical histories of the theater veterans with and without PTSD. His study found a link between PTSD and autoimmune diseases.

"While no difference was found in the prevalence of autoimmune diseases between era and theater vets, theater veterans with comorbid-PTSD were more than 3 times more likely to have autoimmune disease than theater veterans without comorbid PTSD. Specifically, 19% of men with comorbid-PTSD had an autoimmune disease, compared with 6% of the PTSD–negative men. Men with comorbid-PTSD also had biological characteristics consistent with autoimmune disease, including abnormally higher levels of T-lymphocytes and neurophils, and lower levels of testosterone."

"Men were diagnosed with 'comorbid-PTSD' (124 men fit this category) if they reported higher levels of PTSD symptoms in the past six months, in addition to experiencing higher levels of depression, hysteria, paranoia, and schizophrenia symptoms. A veteran was classified as having AD (autoimmune disease) if he had one or more of 20 such diseases, including rheumatoid arthritis, psoriasis, multiple sclerosis, insulin-dependent diabetes, hypothyroidism, Graves' disease, and inflammatory bowel disease."

Long Term Effect of PTS

Dr. Boscarino explained that "those with comorbid-PTSD represent a group of men with a high level of psychopathology and mental disturbance. In the long term, this can have a devastating effect on the body's neuroendocrine and other biological systems, putting the victim at risk for autoimmune and other diseases." The author also noted that autoimmune disease probably effects Vietnam War veterans even more today than 15 years ago, when the Center for Disease Control data was collected. "I would expect that the prevalence of autoimmune disease among the PTSD-positive veterans would be significantly higher if the follow-up exams were conducted today." Dr. Boscarino added "Combat veterans should be aware of this potential link and should discuss this with their doctors if they have any concerns."

In an Associated Press release, reporter Matt Crenson, quotes Dr. Boscarino as stating that his research also showed that Vietnam War veterans with PTSD were also more likely to suffer from coronary artery disease. The AP article quoted Rachel Yehuda commenting on the news of Dr. Boscarino's research findings. "The lesson here is that when someone has been exposed to extreme trauma they're in the spotlight for a couple of days, but we don't brace ourselves for the long haul at all." ##

Phone numbers for WDVA and King County Veterans counselors and contractors are listed in alphabetical order.

Steve Akers, MSW, Everett……425 388 0281
Clark Ashworth, Ph.D., Colville……...509 684 3200
Wayne Ball, MSW, Chalan & Douglas…509 667 8828
Bridget Cantrell, Ph.D., Bellingham...….360 714 1525
Dan Comsia, MA, King County……..253 840 0116
Paul Daley, Ph.D., Port Angeles……...360 457 4357
Duane Dolliver, MS, Yakima...……509 966 7246
Jack Dutro, Ph.D., Aberdeen……...…….360 537 9103
Emmett Early, Ph.D., Seattle……....206 527 4684
Dorothy Hanson, MA., Federal Way ...…253 841 3297
Tim Hermson, MS, Kennewick……..509 783 9168
Bruce Harmon, M.Ed., Renton...…….…425 277 5616
Bill Johnson, MA, Mount Vernon……...306 419 3600
Dennis Jones, MA, Mount Vernon…..….360 419 3600
Bob Keller, MA, Olympia……360 537 9103
Frank Kokorowski, MSW, King Co VP..206 296 7565
Bill Maier, MSW, Port Angeles, Sequim.360 457 0431
Brian Morgan, MS, Omak……....509 826 0117
Mike Phillips, Psy.D., Issaquah.....…..…425 392-0277
Dwight Randolph, MA, Seattle..…….….206 465 1051
Stephen Riggins, M.Ed., Seattle……..206 328 5626
Ellen Schwannecke, M.Ed., Ellensburg...509 925 9861
James Shoop, MS, Mount Vernon……360 419 3600
James Sullivan, Ph.D., Port Orchard...….360 876 2322
Ricardo Swain, MSW, Seattle……...…...206 372 8496
Darlene Tewault, MA., Centralia...…….360 330 2832
Tom Wear, Ph.D., Seattle…….……206 527 5382
Stephen Younker, Ed.D., Yakima……...509 966 7246

WDVA PTSD Program Director:

Tom Schumacher…… ….……...…360 586 1076
Pager……...360-456-9493 or 800 202 9854
Fax……....360 586 1077

To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation will suffice to prove the veteran's military service. You are encouraged to call Tom for additional information or for referral.

It is always preferred if the person who refers someone, telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a strict and tight monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning .Some of the program contractors conduct veteran and spouse groups, as well as and individual/ family counseling. ##

Gender Variable Elusive as Causal Link Between Suicide Risk and PTSD Co-morbid With Major Depression

Researchers from the New York Psychiatric Institute of Columbia University examined 156 patients admitted to their hospital for symptoms of PTSD, along with depression, impulsivity, aggression, hopelessness, substance abuse, suicidal ideation and intent. The researchers had hypothesized "that depressed patients who also had the diagnosis of PTSD would show more suicidal behavior." Maria Oquendo, M.D., et al., published their findings in the *American Journal of Psychiatry* [1003, 160(3), 580-582]. They found that "more of the depressed patients with lifetime PTSD were suicide attempters than those without PTSD…." The research group also found that "suicidal ideation was most severe in the depressed patients who had current PTSD and, therefore more symptoms, suggesting that suicidal ideation lessens in major depressive episodes once PTSD subsides."

Women Outnumber Men

Of the 156 subjects sampled, 24 were diagnosed with lifetime PTSD and 15 with current PTSD. Those with PTSD did not differ on most variables measured, although, the authors note, "women outnumbered men by a ratio of 6:1 in the group with depression and current PTSD and 10:1 in the group with depression and lifetime PTSD."

Oquendo, et al., also reported a prevalence of women in the sample of patients with PTSD comorbid with depression. They noted that "among the 62 subjects who reported abuse (40% of the study group, regardless of PTSD status), more women than men had lifetime PTSD (ratio 8:1), although the distribution of men and women was even in abused subjects without lifetime PTSD…."

Gender Not Predictor of Suicide

Commenting on their research findings, Oquendo, et al, observed that "the higher prevalence of PTSD in women and their greater risk for suicidal acts may explain the preponderance of women in the group with major depressive episode plus PTSD, which had more suicide attempters. However, the regression models did not find sex [gender] to be a predictor of attempter status. Whether women are exposed to more traumata or are biologically vulnerable to developing PTSD after trauma are important considerations, since more women than men in our group of inpatients reported abuse in childhood and developed PTSD."

Oquendo, et al, concluded by stating that "the greater risk of suicide attempts in patients with PTSD plus major depressive episode underscores the need to assess depressed patients for PTSD to ascertain accurate risk for suicidal acts." ##

War Veteran Research Supports Concurrent Treatment of Alcohol Misuse and PTSD

Noting that alcohol abuse is commonly found comorbid with PTSD, researchers from the University of Queensland in Australia questioned the influence on symptomatology when alcohol problems were treated simultaneously with PTSD. Reporting their results in the *Journal of Traumatic Stress*, [2003, 16(1), 27-34], Stanley Steindl, et al, examined 608 consecutive admissions to multiple Australian treatment centers for combat veterans with PTSD. They noted that most of the patients were Vietnam War veterans. Approximately 30% of the research participants required detoxification from alcohol.

"Treatment was of 3-month duration and included 4 contact days per week for 6 weeks followed by a 1-2 contact days per week for a further 6 weeks. Treatment staff obtained the follow-up from participants at 3-and 9-month posttreatment, …" (p. 29). "At intake, 67.9% of the sample was classified as hazardous drinkers. At follow-up, 59.9% of the sample was classified as hazardous drinkers" (p. 30). "The total sample showed significant improvement in alcohol use from intake to 9-month follow-up."

Hazardous Drinker More Severe PTSD

Steindl, et al., found that "the drinking status of the participants prior to treatment did not predict their PTSD symptoms at follow-up. However, drinking status at follow-up was significantly associated with PTSD symptoms at follow-up" (p. 31). "When compared to new low-risk drinkers, unchanged hazardous drinkers had more severe avoidance, numbing, and arousal symptoms. When compared to unchanged low-risk drinkers, unchanged hazardous drinkers had more severe arousal symptoms" (p. 31).

The authors noted that their research did not directly compare treatment techniques, (i.e., alcohol treatment first followed by PTSD treatment, or simultaneous treatment of both disorders), but contended that "it provides some support for the simultaneous approach without detrimental effect" (p. 32) They noted that "those who were unable to moderate their alcohol consumption reported ongoing strong arousal symptoms." Steindl, et al, concluded that "the key role of arousal symptoms is underscored by unchanged hazardous drinkers differing from unchanged low-risk drinkers only in terms of their arousal symptoms" (p. 32). "Teaching individual alternative strategies for coping with arousal, and anger in particular, as well as enhancing their confidence in their use of those strategies through in vivo practice, may have a positive influence on both PTSD arousal symptoms and alcohol misuse" (p. 32). ##

VA Cuts: **Continued from Page 1.**

which was "already limiting services because of heavy demand, will not be able to help the vets who return from Iraq."

The *Times* article noted the news imagery generated by the so-called embedded journalists in the U.S. war with Iraq. "The helmet- and tank-mounted cameras beaming live images of war into American living rooms take the men back to their own combat duty in the lush jungles of Vietnam. The helicopters in Iraq become the helicopters that swept over rice paddies to retrieve wounded soldiers. The sound of a rocket-propelled grenade hasn't changed."

The *Weekly* article by Rick Anderson, cited earlier, leads with a story of Medal-of-Honor winner Joe Hooper, a Washington resident who died at the age of 40 of cerebral hemorrhage, following periodically severe bouts of binge drinking. David Willson, editor of *The Viet Nam War Generation Journal*, was quoted in the article as observing that Hooper was "a casualty of war, and you can expect more of the same after Iraq." Willson, a retired librarian who had worked with Hooper on a collection of war literature, said, "Look at history—this is a country made by war on the backs of vets who have never, ever been treated as promised."

Long Term Losses

It seems that after each war there is a sense of unfinished business. The war veterans, who accumulate despite their inevitable attrition, testify to the fact that the physical and emotional sequelae of war traumas linger on, while the nation's eyes are on the current sensational headlines. The risk of glamorizing war's adventures, as the media and the national leaders will do, is in denial of the long-term costs. No one calculates the losses that accumulate *after* the war is officially over. The toll then begins to accumulate, such as losses in job and tax revenue, institutional costs for assessing and treating veterans for the problems resulting from traumas during military service and the accumulating problems that result from long term chronic stress. The short term sweet appeal of federal budget cutting is turned sour when veterans must wait two years for treatment and are not given available procedures because they are too expensive to perform. Doing more for less means fewer care providers seeing more patients and stretching out appointments, and for many it means spending a day in a hospital waiting room as the short-handed staff try to cover for something unexpected. The "can do" attitude of hospital administrators has the false ring of a salesman touting a product he can't deliver. There is a falseness to staffing medical doctors who never see veteran patients, but are counted anyway as if they were not just there to gather data on prestigious university-affiliated research grants. What mysterious illness will arise from this latest Middle East war and, more importantly, how long will veterans go without identifying war-related problems because the financially strapped VA did not distribute information, did not reach out to the veteran community out of fear that, if they did outreach more patients would be created? ##

Gun Ownership Linked to PTSD

—But the combat variable was not controlled

Researchers at the Central Arkansas VA Healthcare System examined the link between gun ownership and PTSD. In a research report published in the *Southern Medical Journal* [2003, 96, 240-243]. Thomas Freeman and colleagues reported that they examined three groups of patients for aggression, hostility and gun ownership. Research subjects were patients diagnosed with PTSD (33), schizophrenia (23), and "substance abuse disorder" (22). The on-line journal *Medscape* reported on the outcome on 4/9/03. The authors found that "Veterans with PTSD owned four times as many firearms as other veterans…." Members of the PTSD group "were also more likely to report dangerous firearm related behaviors, such as aiming loaded guns at family members or friends, patrolling home property with loaded guns and contemplating suicide with a gun." The report also noted that the PTSD group "showed the highest levels of aggression and hostility."

A significant criticism of the article comes from the *Medscape* Reuters review, which noted that the PTSD group was "primarily composed of Vietnam-era combat veterans," implying that the other two groups were more heterogeneous. The classical conditioning of experience in combat would have been controlled if the groups were divided into combat veterans with PTSD and those without PTSD. An even more sophisticated design might examine PTS symptoms in combat veterans, looking for a simple correlation between number of symptoms and the number of guns, since sub-clinical PTS has also been reported to influence mood, anger, and hostility.

The report from Reuters Health Information concludes with the observation that "although the authors advise physicians to ask veterans about their use of guns, they caution that the findings may not apply to the larger population of PTSD patients. Everyone in the study was a male veteran, they point out, and most were unemployed and had experienced PTSD symptoms for at least 30 years." ##

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. We are inclined here at the *RAQ* editorial offices to regard such communication with avid interest and will likely publish it in upcoming editions, assuming it meets our high standards of not being obscene or anonymous. And if you have a workshop or a book experience to tout, rave or warn us about, the *RAQ* may play a role. We are completing our seventh year of publication with this issue. We expect to continue with volume 8, but we have no lock on the future. Email or write to WDVA.

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Movie Reviews:

Till the End of Time — Le Boucher

By EE

Till the End of Time got short shrift at the Academy Awards for 1946, upstaged by the splashy *Best Years of Our Lives.* The B-movie version of the returning WWII veterans was directed by Edward Dmytryk, one of the masters of *film noir*. This movie, however, suffered as a drama. Guy Madison as Cliff and Robert Mitchum as William Tabeshaw, were discharged from the Marine Corps and the scenes at the San Diego training facility would excite nostalgia in many former Marines.

Screenplay was my Allen Rivkin from a novel, *They Dream of Home*, by Niven Busch. The plot quickly establishes the Marines' combat credentials as nothing less than heroic: the clerk announces that they are veterans of four memorable Pacific campaigns. They are both highly decorated and Mitchum's Tabeshaw has a plate in his head, for which he gallantly declines compensation.

After his return to his California home, Cliff meets Pat, played by Dorothy McGuire, whose husband was killed on his third combat mission with the Air Corps. "They ought to give Purple Hearts to war widows," says Cliff. Cliff's mother repeatedly discourages him from talking about his war experiences. "Don't talk about it, Cliff." "I know you don't want to talk about it."

At a party given by his parents, Cliff's father and a friend of his father's jocularly compare their past war experiences with his.

In a significant moment, Cliff and Pat are in a restaurant coffee shop and come to the aid of an army veteran who has a bad case of the shakes. "Getting the shakes, dog face?" asks Cliff. The dogface says he's has just got out of the veterans' hospital and is on his way home to Boise. He says that the doc said "they'd wear off in time." He decides that perhaps he wasn't going home to Boise after all and instead would go back to the hospital.

Cliff meets with his Marine buddy, Bill with the plate in his head. Together they go visit Perry, played by Bill Williams. Perry was a former boxer who lost his legs in the war. He is training another boxer from his wheelchair. He refuses to wear prostheses. "What can a man do who has no legs?" His mother politely refers to FDR.

Cliff's mother and father are "disappointed" that Cliff doesn't want to look for a job. He finally takes a job selling furniture but abruptly quits. "What's burning me up? I'm edgy. Somebody stole my time."

Robert Mitchum's Bill Tabeshaw shows up having headaches and refusing to go the VA hospital.

A brawl occurs in a tavern where many veterans are gathered. In an interesting subtext, veterans organizers, calling themselves "American War Patriots," attempt to recruit Cliff and Bill, who are angered when they discover that the "Patriots" allow no Jews or Negroes, and a rousing fist fight ensues. Part of the fight is rather light as Perry shows up with his prostheses and partakes in whacking people who are within his range. Bill gets hit in the head and is hospitalized.

Guy Madison's Cliff gets most of the screen time. His Marine war veteran is cool and insouciant. He is not interested in working for a living, but would like to lie around on the beach till he's broke. His emotions seem contained. He consuls Perry, "You have no beef, only the ones who are never coming back."

Bill and Cliff decide that they are going to start a ranch and hire other war veterans.

Till the End of Time suffers from the predominance of Guy Madison and presages the popular screen appeal of Robert Mitchum. Personally I love movies from the 1940s because of their feeling for the era of my childhood. The movie, however, suffers from the negative detachment of Madison's Cliff. Avoidance, in this case, is *not* doing, which is a poor symptom for film. The brief scene of the dogface with the shakes appeals to the need to visually show the audience what war veteran readjustment is all about. Bill's plate in the head causing him pain is a concrete way of representing intractable pain in war veterans. The handy visual technique of the flashback was yet to be adopted in Hollywood, although it had been used in France 20 years earlier.

Le Boucher (The Butcher)

This 1969 suspense film by French director Claude Chabrol takes a hard look at the 15-year army veteran of colonial wars in Algiers and Indochina. André Génovès plays the war veteran, a town butcher. We see him at a wedding, carving a piece of meat for the guests at the wedding reception. He is sitting next to the town's school mistress, Helene, played by Stephane Audran. Later, when a girl is found dead in the woods on a school outing, the butcher reflects that he has seen so many dead bodies—by the truck full. In an important suspense clue, Helene finds a cigarette lighter at the murder scene, like the one she gave to the butcher. She does not report the evidence and later cries with relief when the butcher lights her cigarette with the same kind of lighter.

Finally, however, the butcher is revealed as the murderer and confronts Helene with a large notched knife. He says "I kill them with this, with this knife. I can't help it. It takes hold of me like a nightmare." He then proceeds to stab himself in the stomach. On the way to the hospital Helene kisses him and he speaks lovingly to her as he is dying. "I know about blood," he says, then adds ironically, "When I was a kid I fainted at the sight of blood." ##

Movie Reviews:

Blind Fury and *Little Boy Blue*—The damages of war linger on.

By EE

Blind Fury

In *Blind Fury*, filmed in 1989, Rutger Hauer plays Nick Peters, a Vietnam War veteran blinded by a mortar blast just after his comrade, Frank Devereaux (Terrance Quinn) fled under fire. Nick is captured, not by the enemy, but by what appear to be primitive villagers. Curiously, they teach blind Nick over a long period the art of Japanese swordsmanship. Of course, for sightless Nick, swordsmanship required the extreme refinement of his remaining senses.

The next scene segues to Houston, Texas, years later, where Nick, a wayfarer, visits a roadside café and demonstrates that he has so refined his mystical sense that he humorously defeats local bullies. Meanwhile, we see that Frank Devereaux, the vet who abandoned Nick, has lost control of his gambling and is being forced into making a designer drug to pay off his debts. (Frank became a chemist after the war.) The chief villain, MacCready is played by Nobel Winningham. It appears that Frank has also abandoned his family because of his gambling habit.

Just as Nick shows up at the Devereaux house looking for Frank—to forgive him, we later find out—the criminals arrive and kill Frank's estranged wife, and would have kidnapped little Billy, but for the blind veteran. Nick promises Billy's mom, before she dies, that he will deliver her son to his erstwhile father. Nick then takes Billy by Transcontinental bus to Reno, Nevada, with a variety of adventurous rest stops, the last of which involves the blind veteran chasing Billy through a field of tall corn as comic villains try to kill him. Nick kills them all, slicing each uniquely, but the comic play mixing barnyard villains with Samurai sensibility falls flat.

The boy and his blind protector finally arrive at Frank's house to find Annie, played by Lisa Blount, who seemed to have more talent than she needed. There is more fighting as the blind swordsman slashes his way to the top criminal, MacCready, finally reuniting the boy with his father. In the final cacophony of gunfire and pyrotechnics, Frank, who seems to have abandoned Nick yet again, reappears and saves the day, and in the final scene we see Nick walking on down the highway as Billy calls for him.

The idea that a wound is an opportunity to learn is vividly manipulated here. The Blind Swordsman is a Japanese samurai tradition and an expression of the mystical tradition of enlightenment, in which the wound opens the pathway to extraordinary powers.

Blind Fury is directed by Phillip Noyce and written first by Ryozo Kasahara, and into a screen story by Charles Robert Carner. The movie ultimately sabotages itself with poor taste. The refinement of Nick's sensibilities is played off against good ol' boys, ethnic strongmen, and buffoons. Nick defeats them all with too much ease.

Little Boy Blue

John Savage plays Vietnam War veteran Ray West in a tawdry, intense story of kidnapping and revenge. Ray lives on a piece of rural property in Texas, near Austin, with his wife and three sons. His older son, Jimmy (Ryan Phillippe) is just out of high school and cares for his younger brothers. Natassja Kinski plays Ray's wife. Together they run the Rattlesnake Bar. "Some dive. Nasty joint," says one visitor, who happens to be a grizzled private detective who runs afoul of Ray. Savage plays Ray as a paranoid, rigid man with an Aryan face. He brings a peril to every scene as he seems about to go into a rage.

Jimmy is trapped by his need to care for his little brothers. He talks to the mailman who drives the rural route and delivers Ray's VA disability checks. The mailman did two tours in Vietnam, he announces. Jimmy sees Ray undressing and views his colostomy bag.

Most of the movie takes place in Ray's trashy yard, where there are shacks, the hulks of old machinery and a dilapidated Volkswagen van. Ray coerces Jimmy to make love to Kate while he watches. We later learn that the two young boys are Jimmy's children with Kate. Ray kills the private detective. Eventually the woman who hired the detective (Doris, played by Shirley Knight), comes to town and tracks down Ray. Seems Ray, while still in uniform, was picked up by young Doris and her husband in that very VW van. Ray wanted to hold their infant son. She let him and he then shot her husband, tied her to a tree and kidnapped her son. She tells all this to the police, but has not yet met Ray, When she does go to the Rattlesnake Bar and sees Ray, she recognizes his blond grin. Doris makes a late night visit to Ray's property toting a shotgun, looking frighteningly like Kathy Bates in *Misery*.

The steamy plot of *Little Boy Blue*, released in 1990, could well have been concocted by Tennessee Williams or William Faulkner, but was actually written by Michael Boston. Antonio Tibaldi directed. Tyrin Turner does a credible job as the young policeman who investigates the murder of the detective so persistently. Natassja Kinski is believable as Ray's passive, weak-willed wife.

At one point Ray tries in a sobbing, halting way to describe to Jimmy the impact of watching someone burn from "willy pete," white phosphorous. Jimmy is impatient and ready to leave, saying "I don't care, I don't care."

Two films show Vietnam War veterans struggling with their wounds. The veteran in *Blind Fury* copes heroically, if unrealistically, while the veteran in *Little Boy Blue* all too realistically destroys his life and nearly everyone around him. ##

PTSD and Control

By Jim Shoop

The exposure to trauma and the internal emotional and cognitive reactions of fear, despair, shock, horror, and hopelessness are the antithesis of control. The environment is out of control and the internal experience is out of control. Perhaps then it is no wonder that almost all of my traumatized clients suffer over issues of control. They fear they will confront a situation that is *out of control* or fear they will *lose emotional or behavioral control.*

It is my surmise that *control issues* are central to an understanding of PTSD and a valuable paradigm for intervention.

Chronic vigilance and environmental scanning are diagnostic indicators of PTSD in combat vets. We are well aware of the many ways vets seek to control their environment. They are cautious, aware of dangers others never even see; they check their perimeters. When they see a person or situation that kindles a sense of threat they become aroused, ready to fight or flee. It is my sense that this perception of threat, real or imagined, triggers the reactive phases of PTSD and that the fear of losing emotional or behavioral control overwhelms the individual. Thus it is not just the re-experiencing of trauma that is at issue but the potential and highly fearful re-experiencing of behavioral and emotional chaos. These fears lead to numbing, depression, isolation and a retreat from more pro-active forms of coping.

We are aware that many vets fear their PTSD Compensation and Pension examinations. Certainly the situation is rife with difficulty. The vet must travel to the hospital, find parking, find where he or she needs to go in the hospital and then confront a stranger who will ask the vet to "spill my guts". It is my impression it is not the potential re-experience of the trauma that is central but the fear, on the part of the vet, that he or she will break down and lose control. They fear they will sob uncontrollably or get so nervous they won't be able to speak or cope, or that they will get so angry they might become assaultive or that they will flee. The experience of a 'judgmental other' is a powerful trigger.

If control of emotions and behavior is a core issue, we would expect to find persons and situations that might challenge control as being of special concern to the PTSD impacted veteran. Do triggers such as: fireworks, pushy or aggressive people, traffic, crowded public places, crying infants, rebellious teens, argumentative or critical partners, rude store clerks and their ilk sound familiar? This has become the 'stuff' of many counseling sessions. It is central to the understanding of PTSD not because it necessarily elicits an intrusion of the trauma but because it triggers a fear of a loss of control.

Much has been written regarding PTSD and associated issues of control. Combat vets with PTSD are often portrayed as persons who quickly escalate out of control, reacting to perceived threats with aggression. Although this can and does happen, my experience suggests that the more typical combat vet is the emotional and behavioral opposite. They so control their emotions and behaviors that they become impaired in their ability to cope. They become anxious and apprehensive, fearing some sort of "meltdown". They more typically retreat, flee, or "bunker in" than react with aggression. Perhaps combat trauma somehow elicits a knowledge of self that is so alarming in its animal intensity that it is always and forever a burden; a "beast" that must be contained.

I find many of my vet clients so invested in "the emotional center lane" that any deviation produces unease. Many seek prescription medication or they self medicate in order to maintain some sort of "emotional flat-line", a chemically mediated sanctuary.

Although introducing such a control model is overly simplistic it can have value for some PTSD impacted vets. Many of my clients have gained some sense of insight into their own behavior. They can see how they have battled with issues of control internally and externally. It can introduce choice where none was perceived before. Some are willing to risk an increased level of emotional experience without the omnipresent fear they will lose their emotional center or be unable to return to it. Others can see how they have narrowed their comfort zones and how they are inching toward agoraphobia. ##

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